DRUG/MEDI-CAL CLAIMS AND BILLING INFORMATION

1. LABEL FORMAT FOR TAPES/DISKETTES

The tape/diskette label format is mandatory and it must agree with the information on the tape/diskette. If there is a difference between the label information and what is actually on the tape/diskette, the whole claim will reject and the tape/diskette will be returned to you for correc-tion. This delays processing and, ultimately, payment.

The label format for diskettes that was distributed with the Provider version of the Paradox Runtime Diskette package was incorrect. The label reads total number of units. That should be corrected to read total number of claims on the disk. A copy of the corrected label is enclosed.

The tape label format is the same as for diskettes.

2. SUBMISSION INSTRUCTIONS FOR TAPE/DISKETTE AND HARDCOPY CLAIMS

Claims must be submitted to the Department of Alcohol and Drug Programs (ADP) within 30 days after the end of the month of service (Title 22 CCR Section 51490.1[a]), except for Good Cause (Title 22 CCR Sections 51008 and 51008.5).

For county diskette submissions, all providers must be rolled up into one file on one diskette. The County Paradox Runtime program can help you do this. If it takes more than one diskette, use the same file name on each diskette. Do not submit a ZIPPED file; it will not be processed by the billing system.

When submitting a tape/diskette claim, submit one printout of the claim. For a hardcopy claim, submit the original.

Diskettes will not be returned to Counties/Direct Providers unless requested. If you specifically request the return of your diskette it will be returned in a plain envelope with a DO NOT X-RAY label. If you want your diskette returned to you in a disk mailer, include a disk mailer when you submit your claim.

3. GROUPING OF SERVICE FUNCTION CODES

When claiming for Narcotic Treatment Programs (NTP) services, group each different service type(20-22 Methadone, 23-25 LAAM, 26-27 Individual Counseling and 28-29 Group Counseling) separately, if possible. If it is not possible to group them on the claim,

separate them on the invoice.

4. REVISED INVOICE - ADP 1592

The "Monthly Claim for Drug/Medi-Cal Reimbursement and Monthly Provider Service and Revenue Summary" (ADP 1592 - Invoice) was revised in August 1997. It was distributed with the Provider version of the Paradox Runtime diskette package. All Counties/Direct Providers should send a revised ADP 1592 (8/97) with their monthly D/MC claims. A copy is enclosed. The invoice must have three original signatures.

When calculating the dollar amounts on the ADP 1592 form, please do not round the figures. The shading on the form does not mean you cannot put figures in those areas but is meant to show where to place the cents.

Send one original with original signatures and three copies of the invoice with your monthly D/MC claims. Invoices (ADP 1592) should be organized so that all copies for Program 20 are stapled together and all copies for Program 25 are stapled together.

5. SHARE OF COST (SOC)

If the Point of Service (POS) device or the Automated Eligibility Verification System (AEVS) does not give an Eligibility Verification Code and the client has a SOC, that SOC must be cleared through the eligibility system before the client is eligible for Medi-Cal.

If a SOC has been collected from the client, the provider must report it to the County. The County must then report the SOC amount on the Monthly Claim for Drug/Medi-Cal Reimbursement and Monthly Provider Service and Revenue Summary (ADP 1592) and deduct it from the providers' claim for services rendered.

6. MINOR CONSENT AND EPSDT CLAIMS

Minor Consent and EPSDT claims must be submitted on separate forms from the regular D/MC claims forms and should be accompanied by a separate monthly invoice (ADP 1592) with three original signatures.

7. REVISED MONTHLY INTERIM PAYMENT CLAIM FORM

Monthly Interim Payment Claims (ADP 7890) must be submitted on the form revised in July 1997. A copy of ADP 7890 is enclosed. Correctly identify the month, fiscal year and the ADP contract number.

8. AUTOMATED BILLING SYSTEM REPORTS

The Summary Reports from the Department of Health Services (DHS) Automated Billing System will no longer be mailed to Counties/Direct Providers. The information supplied on these reports is duplicative of the information on the detailed reports, which you will continue to receive. The following Summary Reports have been discontinued:

a. Denied Claims Batch Summary Report

b. Denied Non-Title XIX Services and Expenditures by County

c. Detailed Report by Provider of Denied Non-Title XIX Service and Expenditures

d. Approved Claims Batch Summary Report

e. Aged Suspended Claims Batch Summary Report

f. New and Reedited Claims Suspended for Error Correction Batch Summary Report

9. DISALLOWANCES FY 1996-97 AND PRIOR

Disallowances must be taken in the same fiscal year in which the service is provided. The provider should send the pink copy to the State, and send the white and blue copies to the County. The County should then deduct the disallowance from the next current invoice for the same fiscal year, and then forward the white copy with the invoice to the State. If a disallowance (white copy) is taken from the wrong fiscal year, the State will remove the disallowed amount from the invoice and deduct it from another claim in the proper fiscal year, if possible. If this is not possible, the State will make an adjustment at cost report settlement. If the white copy is not submitted to the State, the pink copy will be held and deducted at cost report settlement.

Disallowance forms (ADP 5035B) are to be used only for FY 1996-97 claims. A new form is being developed to adjust erroneous claims for FY 1997-98.

10. CLAIMS RESUBMISSION

A claim cannot be resubmitted unless it has first been denied. The resubmission of a denied claim must be made no later than six months following the rundate of the "Denied Claims Report." When claiming a resubmission, include as a package:

a. The resubmission document (ADP 1584, Eligibility Worksheet); and

b. A copy of the Denied Claims Report.

If the resubmission is due to a deleted claim on an Error Correction Report (ECR), include in the package:

a. The resubmission document (ADP 1584); and

b. The ECR deleting the resubmitted units of service.

11. ORIGINAL SIGNATURES REQUIRED

Drug/Medi-Cal Claim Invoices and Monthly Interim Payment Claim forms require an original signature(s) for processing. Since signatures written in black ink are hard to distinguish from a photocopied one, we must require that you NOT use BLACK INK to sign any of these documents.

If you are submitting your D/MC claims on a Paradox Runtime diskette with an automated invoice, you may submit a permanent signature document, to be kept on file at ADP, in lieu of original signatures on the Invoice (ADP 1592).

If you submit your D/MC claims on diskette without an automated invoice and want to automate your invoice you must create it in WORD for Windows no higher than 6.0 or WordPerfect no higher than 6.1. It must be a text file.

A signature document form is enclosed.

12. ASSEMBLY BILL (AB) 2071 - 45 DAYS TO D/MC REIMBURSEMENT

AB 2071, Section 11758.46.(f)(1) and (2) specifies that reimbursement for Drug/Medi-Cal claims from both State General Funds (SGF) and Federal Medicaid Funds must commence no later than 45 days following the receipt of an approved contract, the enactment of the annual Budget Act for the appropriate fiscal year, and a complete and accurate claim. Claims must be processed through the DHS Automated Eligibility System to check for client eligibility and accuracy. If all requirements have been met, the 45 days for reimbursement of Federal Medicaid Funds begins from the Current Date printed on the upper right hand corner of the Approved Services Report issued by DHS. The SGF reimbursement begins 45 days from the approval date of the Monthly Interim Payment Claim.